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ABSTRACT

Discussed are attempts made by staff at the Community Mental Health Center of the New Jersey School of Medicine to develop an ongoing working relationship with pediatric neonatologists, house staff, and nursing staff in order to promote their attunement to mental health needs and obtain access to their expertise. After a description of the center and the dimensions of infant mental health care, the document provides examples of cooperation in clinical work and ways of building liaison and overcoming conflict. Building the working relationship is a complex process in which all sides try to balance the common interests in tasks, school, and clientele against the special interests of departmental, professional, and individual success and recognition. Cooperation in this process appears possible only by making continued helpful nonpartisan contributions and by displaying genuine openness in communications, in the hope that these efforts will be reciprocated. (RH)

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Liaison Problems among Infant Psychiatry, Psychology, Pediatrics, Nursing, and Social Work in Infant Mental Health Care

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In infancy, general physiological, neurological, cognitive, and affective functions are closely intertwined. Hence, one characteristic of an Infant Mental Health Service is that it requires a particularly close cooperation between all infant health professionals -- psychologists, psychiatrists, pediatricians, neurologists, pediatric nurses, social workers, and other specialists. This is especially true in cases of a baby's marked prematurity and genetically or environmentally induced pathology. Many health professionals are typically uninformed about, and unaccustomed to, the use of infant mental health services. Furthermore, in many hospital settings, the cooperation between departments and between occupational groups is far from ideal.

I will be discussing our attempts at our Community Mental Health Center to develop an ongoing working relationship with pediatric neonatologists, house staff, and nursing staff at our affiliated hospital, in order to promote staff's attunement to mental health needs and our access to their expertise. I shall report on the considerable problems encountered and on some of the successes enjoyed.

INSTITUTIONAL SETTING

The Community Mental Health Center, part of the University of Medicine and Dentistry of New Jersey, is located in Newark, which, according to recent Census reports, has the highest poverty rate of any city with more than 100,000 population in

the United States (Census Tracts, 1980). There exists a high rate of teenage pregnancies and teenage motherhood--sometimes at ages as low as 13 or 14 years, especially among minority populations which is consistent with nation-wide statistics (Hammond & Martin, 1985). Generally, among these young mothers, there occur many premature births, extremely low birth-weights, (McArarney, 1983) endocrinological and other organic deficiencies in mothers and babies, as well as drug and alcohol related problems (NICHD, 1984). There are long term incubator periods for babies requiring enriched oxygenation, intravenous feeding, medication, and other support systems, which prevent close mother-baby contacts. There frequently exists rejection of parental obligations, absence of mothering skills, despair and depression of mothers who are themselves still children, and a considerable incidence of child abuse and neglect (Hammond & Martin, 1985). These conditions prevail particularly in those cases which are referred to our Infant Mental Health Service.

Among the preschool services provided by our Community Mental Health Center is a Therapeutic Nursery for emotionally disturbed children (age 2½-5 years), Mother-Toddler play groups (with children 18 to 36 months) which facilitate mother-child adjustment during the difficult separation-individuation period, an Infant Mental Health Service for mother-infant dyads (with babies up to 18 months),

and a pregnant teenage service. Furthermore, we act as consultants and therapists in cases referred to us by pediatricians or nurses of our own hospital or by other institutions. Referred to us are the children; but, of course, intensive contact with mothers or other caregivers, and influence on the child-mother relationship, are crucial at the described ages. Referral itself is an indispensable condition of cooperation between pediatrics and infant mental health care. If pediatricians and nurses in high risk neonatology look at their infants as purely medical survival or repair problems (which in physically impaired babies is entirely understandable), if they are uninformed about or unappreciative of infant mental health problems and remediation possibilities, there will be neither referral nor further cooperation for joint intervention.

DIMENSIONS OF INFANT MENTAL HEALTH CARE

Under the described detrimental medical and social circumstances, infants and their caregivers typically require considerable support. For infant mental health professionals I do not have to detail the basic nature of this support.

A fairly typical problem in our clientele is that of mothers who are so overwhelmed by the multidimensional complexities of their motherhood that they are unable to

muster the initiative to communicate with their babies or even to respond to their babies' communication attempts. A primary condition for fostering maternal attitudes is to help the young mothers cope with their own problems. Such problems might include the handling of their babies, their relationship to their mothers and other family members, to the fathers of their babies and perhaps to other male and female friends, their worries about their financial or educational future, and other concerns of importance to them. Only if the pressures of these concerns are somewhat alleviated and if the mothers perceive the infant-mental health workers to be their close allies as well as their babies' advocates and friends, will they be open to accept more than mere material help when offered.. The management of these concerns requires close interdisciplinary and inter-agency cooperation, and the development of trusting relationships with individuals in all support groups, both on the executive and the case management levels.

If the mothering capabilities of the young mothers remain entirely inadequate, be it due to extreme immaturity, substance abuse, psychiatric afflictions or other reasons, foster homes may have to be found. This involves problems which cannot be pursued here: placing babies into foster homes sometimes just transfer them from one place of known to another place of unknown conditions of neglect or abuse.

It follows that close liaison with placement agency personnel is another of the inescapable duties of infant mental health workers.

Babies and their mothers are not the only ones who require understanding, guidance, and psychological support in a medical school setting. Imagine the pressures on the nurses working in a high risk neonatology environment. On one hand they are asked to feed, clean, cuddle, stimulate, medicate and protect their babies and to handle the frequent emergencies typical for such a setting. Then they are confronted by high infant-mortality rates, by requests to shift their mother-substitute role from one to another critically sick baby, by a demanding hierarchic control both on the part of head nurses and medical personnel, by strong blame for actual or perceived mistakes, and by only scant recognition of devotion and success. It is the nurses who really live with the lives and deaths of these infants, not their medical and non-medical superiors. The emotional pressures on this group are so high that, according to my experience, it often leads to a significantly larger incidence of high-tension symptoms, absenteeism, and job turnover than in many other nursing operations. Infant mental health workers wishing to be effective in a hospital setting cannot afford to neglect these problems in the high risk nursery.

Finally, we come to the medical personnel--pediatricians,

pediatric surgeons, obstetricians, psychiatrists, neurologists, and others. Infant mental health workers need them very much: as detectors of deficiencies in mothers and babies, as a source of referrals, as diagnosticians, and as partners in the implementation of therapeutic strategies. But, if the doctors' goals are not purely physiologically defined, the physicians need the infant mental health specialists also: to inform them about the non-medical aspects of infant development, to sensitize them to potential and actual problems in mother-child relationships, and to show them how to use the tests and the therapeutic services which the new discipline has to offer. This requires persistant missionary efforts on the part of infant mental health professionals.

EXAMPLES OF COOPERATION IN CLINICAL WORK

That cooperation among the mentioned disciplines is indispensable for infant mental health practice, will become entirely apparent when the clinical process is illustrated with some examples.

At a monthly meeting, which I regularly conduct with pediatric residents rotating through Neonatology, a pediatrician reported that the police had just brought to the University Hospital a new-born baby found in a paper bag on the porch of a one-family house in Newark. The

baby seemed full-term and in good physical condition. It turned out that the infant was delivered by a 15 year old girl belonging to that home, that neither pregnancy nor delivery were known to her mother, that an earlier baby of the same teenager was being raised by the mother, and that the mother had threatened to throw the teenager and her baby out of the house if a new pregnancy occurred. The question of the pediatrician was whether a child-abandoning mother, such as this 15 year old girl, was not likely to be a child-abusing mother, and whether she could possibly be trusted with the care for her baby.

This question could hardly be answered on the basis of the available facts, and assessments of the teenager, her mother and the home environment were needed. We talked about the psychological coping problems of most teenagers, the enormous stresses on expectant and actual teenage mothers, the nightmare of keeping pregnancy and delivery secret, and the possibility of panicking under the prospects of being turned out of the house with the newborn baby. Such panicking might not be necessarily indicative of a basic lack of mothering capabilities. In addition, the attitude of the teenager's mother might not be entirely inflexible. The group of pediatricians wanted to know about the whole process of evaluating such a situation and of arriving at a practical disposition. This was no simple

question! A healthy infant is allowed to stay in the hospital for only three days. During this time, the teenager and the mother had to be talked to, the mother-infant relationship observed by the Neonatology section's child development specialist, and the family's circumstances had to be evaluated by a pediatric social worker. In short, we had to initiate a high gear operation (1) to assess, as well as possible under the circumstances, the physical and psychological potentials and risks of accommodating the teenage mother and her baby within her family or elsewhere and, (2) to give effect to the needed changes. These tasks would have been hopeless in the absence of previously established close working relationships among all services concerned.

We decided that, if the prospects of accommodation at home were at all reasonable, it would be preferable to house the teenager and her new baby with her family rather than consider foster care. It turned out that the teenager's mother could be persuaded to accept the new baby. Consider the strain on all resources if this arrangement had been impossible. And consider our responsibility if the teenager, in spite of all our evaluation efforts, would have in fact neglected or abused her baby. In principle, this case is, of course, a prime candidate for infant mental health monitoring. But since the grandmother became, in the end, the responsible caregiver we lost track of further

developments. I feared that observed indifference of the mother towards her new baby might, under the known facts of abandonment, be easily interpreted as basic rejection. I, therefore, suggested that psychiatric consultation be sought to exclude the possibilities of paralysing anxiety or post-partum depression.

In summary, the elements of cooperation in this case were as follows: psychological advice was sought by Neonatal Pediatrics and provided by Infant Mental Health; resident education on the psychodynamics of teenage behavior and teenage motherhood was provided; and a process of assessment and disposition was initiated and carried through. The whole experience was discussed and utilized for interdisciplinary training.

Another case was referred to us from Outpatient Pediatrics, by a nurse practitioner who had participated in one of our weekly seminars. It concerned a triad consisting of a a six month old boy, his seventeen year old unmarried mother, and the maternal grandmother in whose home they all lived. Mother and grandmother were very worried about the fact that the baby was extremely passive and unresponsive, and did not crawl or sit up--perhaps he was retarded! The only activity he engaged in, according to their reports, consisted of prolonged aimless grasping hand movements in the air--perhaps he was crazy! Medical examinations did not reveal any pathology, neurological or other. Reassurances about normal differences in the pace of development and about normal practice movements by babies

were not accepted. The nurse practitioner regarded the intensity of the fearful complaints as quite unusual and asked us for assessment.

I very much regret that I can't report this fascinating case in detail. Here is the gist of it: Mother and grandmother accused each other rightiously and visciously of being resonsible for the baby's "signs of mental sickness". The "symptoms" became weapons in their fight. Meanwhile the "retarded" infant boy was left unstimulated and severely neglected. He began now indeed to develop some indications of delayed development which, of course, fueled the discord between the two women. We arranged that the teenager (who was herself eligible for welfare) obtain her own quarters and that the young mother and her baby join one of our mother-toddler groups. We demonstrated to her how nicely the infant could repond to warm communication. It worked! By now the baby walks, smiles, babbles, and has become quite an outgoing little boy. No one ever talks any more about crazy hand movements.

The active cooperation of Pediatrics, Nursing, and Psychiatry paid amply in this case. What at first seemed to be a medical problem, turned out to be the reflection of an intense mother-daughter conflict, nurtured by high levels of anxiety. Note that the attitude of a teenager's mother was also of central importance in our first vignette. This is so frequently the case in our clientele that we often have to deal with a triadic rather than dyadic constellation.

Handling these complications is typically way beyond the concerns and the experience of pediatricians--another aspect of the need for cooperation among the disciplines in the field of infant mental health care.

Our strategies in the two examples above involved combinations of environmental change, psychological support, infant mental health counselling, and preventive intervention. Such combinations are frequently required by infant mental health work within our multiproblem clientele. This does not exclude more conventional psychotherapeutic treatment of mothers with severe individual psychopathology, direct work with malfunctioning babies, and sustained enhancement of infant-mother relations.

BUILDING LIAISON AND OVERCOMING CONFLICT

One of the primary rules for building liaison is to respond readily to one's partners' needs -- real or perceived. I almost started on the wrong foot in this respect. On my early visits to the intensive care nursery, I saw forlorn, sad teenage mothers looking at their tubed and wired incubator babies, afraid of doing anything at all. No one took care of these child-mothers and told them to touch and soothe and "talk" to their crying infants; and no one seemed to inquire about the young mothers' own feelings and fears. I thought that there was lots to do. When introduced to the Chief of

Pediatrics, I reported about my observations and suggested some active "preventive intervention". He remarked that the Chief of Neonatology might well be open to my ideas. Hence, I subsequently began to "suggest". However, the Chief mentioned some pressing needs on her own agenda, which I might be able to satisfy: her high-risk neonatal nursing staff was overwrought and needed care, and her resident pediatricians needed clinical discussions of early developmental problems and infant mental health care methods. Since these were obviously high-priority needs for her, I offered my help--subordinating for the present my immediate mother-infant concerns. This proved effective and led to the first instance of systematic cooperation between Child Psychiatry and Neonatology, in the form of two separate weekly meetings termed "seminars".

The instruction of the pediatric residents went smoothly and did not at all fulfill the dire prediction that Doctors of Medicine would not care to obtain their infant mental health education from a lady psychologist. By contrast, the work with the nurses soon became quite rough, but lasted nevertheless for about eight months. The nurses were upset by the frequent deaths in the high-risk nursery, by mistakes and cover-ups, by intra-staff rivalries, by the lack of specific rights of nurses to resist medical orders which violated their convictions, and by frictions between them

and their supervisors. However, it became increasingly clear that in the presence of their head nurse the nurses neither dared to reveal their anxieties and weaknesses, nor did they voice their real complaints. I decided -- perhaps somewhat rashly -- to ask the head nurse to withdraw from these weekly meetings in order to facilitate supportive and remedial processes. She agreed, with understanding. I did not forsee, however, the vehemence of the nurses' complaints once their superior was absent. Irrespective of the substantive merits of these complaints, I judged that the nursing staff could not adequately function under a regime of extreme discontent. Hence, I did not discourage the nurses' decision to seek a change in supervision, through a letter to the administration, signed by all members of the nursing staff. The change did not come about, but the head nurse learned about my prior knowledge of her nurses' protest action. Henceforth, the weekly meeting with her nurses could not be continued because of "insurmountable scheduling problems". It was a setback which could probably have been avoided. The experience teaches important lessons in the subtle art of cooperation. Advisors can easily get in the middle of intra-departmental struggles. This is particularly damaging if they are coming from another profession or department. It can severely reduce their leverage and endanger their whole efforts. The experience also highlighs the importance of maintaining a routine of checking and counseling with one's

own professional peers and one's own supervisory staff--a precaution which I had failed to take.

This is not the only incident of friction in our liaison relationships. Some referrals to our therapeutic nursery, mother-toddler groups, and infant services come from out-patient pediatrics; others come from in-patient pediatrics and from outside agencies--but very few from Neonatology proper. Why do we not get regular referrals of babies from neonatology, the most obvious source of referrals for infant mental health problems? There appear to be two sides to the liaison ledger. On one side is the fact that the head of Neonatology is a psychologically very aware and responsive pediatrician. In fact, she had formulated herself a program for a Developmental Enhancement Center, which included infant mental health services. This explains why most of my efforts were, in principle, strongly supported by her. On the other side, since our goals were somewhat similar, there was the open question of whether there would be departmentally separate efforts or one joint center, and the less open question of who would control such a center. I guess that control is at least partly dependent on access to funding, and Pediatrics seemed to have the upper hand. I really do not know about such matters and somewhat naively assumed that a joint center would obviously avoid duplication, could offer more variegated special services, and would

therefore be preferred by all. However, I was observing, on the part of both the departments of Pediatrics and of Psychiatry, attitudes and actions that were hard for me to understand, except as the staking out of future claims for control. Cooperation seemed to be constrained by competitive considerations.

The whole situation changed quite radically when the Community Mental Health Center became independent from academic departments and when a new enthusiastic and effective administrator was appointed. At the same time the president of the University began to support a full-fledged Infant Mental Health Service as a visible university contribution to Newark's welfare. New quarters for Infant Mental Health and Toddler-Mother services were designed and recently completed. While we are obviously very happy with these developments, those who nurtured similar plans for Pediatrics were bound to be disappointed. We understand this and are indeed empathic. We have no right to anticipate that this disappointment could affect cooperation relationships. Still, our success requires new investments in productive liaison. Both, in our current operations and for the success of a newly established Infant Mental Health training program*, we need access to and willing cooperation with the personnel of High Risk Neonatology. We have given this situation considerable

thought and want to take the initiative with an offer of good will and support on our part. We have on our staff a developmental psychologist with special expertise in the testing of full-term and premature infants. We intend to offer her services, on a regular basis, to High Risk Neonatology and Infant Pediatrics. This is, of course, an anticipatory mutual assistance offer. It reflects the fact that cooperation is, indeed, a two-sided arrangement, and that one must sometimes initiate or revive the process.

There is always some intertwining of cooperation and competition in interdisciplinary affairs. Liaison is a complex process in which all sides try to balance the common interests in our tasks, our institution, and our clientele against the special interests in departmental, professional, and individual success and recognition. Cooperation in this process can be gained and maintained only by displaying genuine openess in communication and by perseverance in making helpful contributions. And then one hopes for reciprocity.

Reference Note

* Brochure describing Infant Mental Health Training Program is available on request. Write in care of author's address.

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